It is interesting to note the new advertisers appearing in the Journal; also to note the new books, instruments and other medical requirements advertised by the older advertisers. Part of the educational value of the Journal lies in keeping familiar with the articles advertised. It is worth while whether you expect to buy or not. All advertisers in this Journal pass a rigid scrutiny and are reliable and ethical. It is to their interest to put their best foot forward and they do it. Therein lies a real chance for the busy doctor to keep in touch with commercial scientific progress. Do *you* do it?

Special Articles

PRESENT STATUS OF HEALTH INSURANCE IN CALIFORNIA.

By RENÉ BINE, M. D., San Francisco, Chairman of the Committee on Health Insurance of the State Society.

A very prominent gentleman, recently connected with our State government, told us not very long ago that in his opinion, Health Insurance of some sort was so sure to come as the result of public demand, that our office seekers would fall over themselves in their eagerness to indorse such measures, aye, even loudly bringing forth claims of priority in the discovery of the need for such legislation.

He furthermore told us that for a long time the bankers of this State had consistently opposed new banking laws, and would do nothing to help formulate them. To-day they openly admit that they would not go back to the old system if they could.

There is no doubt, and none of us can deny that lack of organization in the medical profession causes much waste. We often do not realize how great the waste really is. In our homes we probably all thought we were economical, until we began to "Hooverize." The railroads managed to make money and apparently do good work, until real efficiency was needed; then they had a great fall, and all the railroad presidents and all the country's bosses are trying to get them together again.

The Social Insurance Commission of the State of California has proposed an amendment to the constitution which, if passed, will enable the legislature to establish a real insurance system. The legislature does not meet in 1918. Nothing can be done therefore towards passing any Health Insurance bill until 1919, provided the amendment is carried in November 1918.

In the meantime, let us, the medical profession, try and work out our own reforms if possible and see to it that, come what may, we protect the community from legislation unless it be practical, sane and desirable.

Your committee published its first report in the June 1917 issue, and to this your attention is again called. We are now debating a number of points, which we are going to detail here, in the hope that those interested will take the time to study them, and the time and energy to write to us, expressing their views. We want help; we want constructive criticism. Remember, please, that we are apt in this, as in other matters, to sit back and feel that "we are satisfied with the present order of things and, well, if something must be done,—oh, well, let George do it."

In April your Committee on Social Insurance will report further on its work. It is going ahead upon the assumption that if the people of our State want and do vote for Health Insurance, the Medical Society of the State of California must help *frame* the final bill and practically *dictate* the actual medical features of the bill.

How does the medical profession of England, after five years' practical experience, regard the Health Insurance Act? "Favorably," finds the British Medical Association after a painstaking inquiry among all local branches and panel committees. And, the Association's Committee remarks, "the degree of unanimity so far disclosed is somewhat remarkable."

The report, which has appeared in the British Medical Journal, points out minor defects in administrative detail that may be easily corrected and suggests that the scheme, which is proving a distinct gain to the medical profession as well as to the public health, be still further expanded.

The points we are studying, and which we would submit to your earnest consideration, follow. We, of course, are assuming the possible passage of a Health Insurance bill. It might be well for County Societies to devote meetings to these topics. When we have gotten a little further in our work we hope to arrange for speakers to visit societies desiring them.

1. Basis of remuneration of physicians.
   (a) salary basis (full or part time men?)
   (b) Fee schedule as at present established for the industrial accident work.
   (c) Capitation.

Growth of *contract* medicine should be recognized—either (1) salary work, when contract made by corporation, or (2) very small capitation, as witness usual lodge salary of $2 per annum per insured, to treat members and families.

Some step in direction of medical and hospital service within the financial grasp of wage earners is bound to be taken. The question is, what step? Health Insurance, through the contributions of employers, as well as employees, and help from the State, offers a source of income larger than possible now for this sort of work.

Also, capitation system or salary system (as in vogue in England) offers possibility of practice of preventive medicine. This could not be had under fee system. Note testimony contained in the English reports in regard to the benefits of the capitation system from a medical standpoint.

Capitation system offers chance for free choice of doctors. Salary system does *not.*

2. Remuneration and Regulation of Specialists.
   (a) Should a different basis of remuneration be adopted for "specialist service?" Should higher standards of remuneration be adopted for specialist service?
   (b) If not, how could you obtain the services of good specialists?

(c) How will it be determined whether an M. D. is a specialist or not?
(d) Should you permit the specialist to be on call for Health Insurance work only part of his time, and require the general practitioner to be on call at any time?

3. Possibilities of Group Medicine Under Health Insurance Organization.
(a) Do you consider it practical to make the group instead of the individual the unit under Health Insurance, thereby requiring the association of general practitioners with the various specialists?
(b) If so, should the group of necessity be attached to a hospital open to Health Insurance members?
(c) Could the specialists in one group be attached to other groups as well?
(d) Would it be possible for the State Insurance Fund to pay a lump sum to the group, allowing the doctors to arrange for division, or should the method and amount of remuneration be determined by the State commission?

4. (a) Should the amount of work to be done under Health Insurance by any one doctor be limited?
(b) Should the number of persons on the panel of any one doctor be limited to a certain fixed number?
(c) Should the number be variable, in the discretion of the commission, or should it be variable merely as between rural and urban districts?
(d) Should the question of the maximum number of patients be left in each instance to a supervisory body or to the Insurance Commission?

5. (a) Should there be a medical advisor in the different districts of the State (assuming that there is to be free choice of physician), who has real disciplinary supervisory powers?
(b) Should this advisor be merely a referee, with power and duty of deciding insured person's eligibility to sickness benefits and having no powers or duty or assisting in diagnosis and treatment?
(c) Should this advisor have such powers as referee plus right and duty of acting as consultant when called in either by patient or physician, his opinion to be accepted or rejected, according to wish of practitioner in charge, as is now customary with consultants?

6. (a) Should any practitioner be permitted to take into a Health Insurance Hospital (i. e., hospital contracting to take Health Insurance patients), operate, etc., without any supervision from hospital head?
(b) Should any restriction be made as to performance of capital operation? If so, what?
(c) Would it be practical to plan two types of hospital: (1) a diagnosis center with its attendant staff of specialists to which all cases of unusual difficulty would be referred and in which the general practitioner must follow the study of patient's case; (2) a general hospital where the doctor can take his patient just as now and at the same time find at this hospital a staff of specialists to assist as consultants, if desired?
(d) Should the State build and equip diagnosis centers where all the specialties would be found (also laboratories, X-Ray facilities, etc.), at the disposal of the general practitioner?

THE VENEREAL SITUATION AMONG THE FORCES AT WAR.

By JOHN C. SPENCER, M. D., San Francisco.

It is the consensus of authoritative opinion that venereal diseases are responsible for more disabled and inefficient fighting men than all other diseases combined. This statement is readily confirmed by reference to Governmental reports from the military authorities of the principal warring nations.

As a basis of computation for an estimate of the ravages upon human life and health, no better testimony is available than that presented in the Lettsomian oration by Sir William Osler.[1] His figures are based on the English experience:

"In 1915, while nine soldiers died every hour, during the same period twelve babies died to the scandal of the country. . . . The gonococcus is the greatest known preventer of life. . . . A conservative estimate of the women sterile from a gonorrheal infection is 50%. From the same cause 30 to 40% of human beings are rendered congenitally blind. Add to these the chronic pelvic mischief and the unhappiness of sterile marriages . . . and the gonococcus is the king among germs. . . . In 1915 syphilis was the cause of 20,000 still-births; between 15,000 to 20,000 died from the same cause during the first year of their life. . . . Out of 562,000 deaths from all causes 10,000 were from syphilis of the nervous system, and 10,000 from syphilis of the vascular system. The grand total of deaths from this cause amounted to 60,000. . . . The last obtainable figures as to the percentage of venereal diseases in the British army showed syphilis 21,000; gonorrhea, 71,000; and chancroid, 6000."

In summing up, he declares that the campaign against venereal disease, to be successful, must prepare the people, first, by educational methods; second, by compulsory treatment.

For the French army the only available figures showing the relative prevalence are from Gaucher.[2] He states that "in the first six months of the war syphilis existed in the ratio of 1–6 of the others, and in the first sixteen months amounted to 33%. About 20% of all venereal disease was among the married men. . . . About 50% of all prostitutes were diseased. . . . During the following eight months, the incidence was increased still further by about 50%, creating the assumption

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* Read before the Urological Section of the San Francisco County Medical Society, October 30, 1917.

1. Osler, Sir William: Brit. Med. Jour., May 26, 1917.
2. Gaucher and Brizard: Ann. de Mal. Venerlennes, Vol. 11, No. 129, 1916.
(Ibid.) Jour. Amer. Med. Assoc., Feb. 3, 1917, p. 384.